STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/29/2011

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R0000	This visit was for the Investigation of Complaint IN00088036. Complaint IN00088036 was substantiated, state deficiencies related to the allegations are cited at R240, R0241, R0247, and R0349. Survey dates: March 25, 28 and 29, 2011 Facility number: 0004686 Provider number: 0004686 AIM number: NA Survey team: Christine Fodrea, RN, TC Rick Blain, RN (March 25, 2011) Ann Armey (March 28, 2011) Census bed type: Residential: 35 Total: 35 Census payor type: Other: 35 Total: 35 Sample: 5 These State findings are cited in accordance with 410 IAC 16.2	R0000	The submission of this plan response and the plan of correction included in is not a legal admission that a deficiency exist or that this sttatement of deficiencies was correctly cited. This is also not to be constructed as an admission against interest by facility or any employee agents and other individuals who draft or may be discussed in this response and plan of correction.In addition preparation and submision of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctne of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on March 31, 2011, by Bev Faulkner, RN			
R0240	(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to implement care as outlined in the resident service plan for 1 of 3 residents reviewed for turning and repositioning in a total sample of 5. (Resident #N) Findings include: Resident #N's record was reviewed 3-25-2011 at 11:30 a.m., Resident #N's diagnoses included but were not limited to diabetes, high blood pressure, and high cholesterol. Resident #N's Assessment and Negotiated Service Plan Summary, dated 2-2-2011, under the heading Special Services, Other, 3 points for frequent turning. The checkmark for other, 3 points and -for frequent turning had been handwritten on the form. There was no date on the handwritten entry to indicate when the plan was updated. A Short Term Change of Condition Report, dated 3-10-2011, indicated	R0240	Residence Director and Wellness Director will frequently schedule a care conference with Resident and spouse to ensure that Residents needs are being met.Residence Director and Wellness Director have set a system in place to ensure that Resident service plans are reviewed regularly and are accurate. Any significant change of condition warrants an update of resident service plans. Residence Director and or Wellness Director will ensure that updates are dated.Residence Director and or Wellness Director have retrained staff to show how changes in resident care are communicated.Residence Director and or Wellness Director will monitor care delivery, document action twice weekly to ensure completion until 100% compliance is achieved. Regional Director of Quality and Care Management and or regional Director of operations will randomly audit documentation during routine house visits at least monthly for the next 6 months and there after as needed.	04/30/2011

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	Resident #N was to be repositioned frequently. An updated Short Term Change of Condition Report dated 3-18-2011 indicated a turning schedule had been posted for signing. The Residential Service notes, dated 3-10-2011, indicate a 1 1/2 inch scabbed area had been noted on the right hip trochanter are. In a confidential interview with a facility staff member on 3-28-2011 at 2:30 p.m., the interviewee indicated there was no communication of Resident #N needing turning and repositioning until the weekend after he developed the pressure area. In an interview on 3-28-2011 at 3:30 p.m., the Wellness Director indicated she was unsure when the service plan had been amended to include frequent turning. In an interview on 3-28-2011 at 3:50 p.m., CNA #1 indicated Resident #N had not been turned according to the schedule in the room at times. A review of the turning and repositioning schedule provided by the Administrator on 3-28-2011 at 8:30 a.m., indicated the turning and positioning documentation had not been initiated until 3-18-2011 at			

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	9:48 p.m. Additionally, the forms did not include documentation that turning and repositioning had been completed on 3-19 at 8 a.m.; 3-21 at 2 a.m., 6 a.m., 12 noon, and 2 p.m.; 3-22 at 12 midnight, and 10 a.m.; 3-23 at 4 a.m. and 10 p.m.; 3-25 at 2, 6, 8, and 10 p.m.; 3-25 at 2 p.m.; 3-26 at 8 p.m.; and 3-27 at 2 p.m. On page 3 the Resident Handbook, dated 7-2006, indicated "The Residence will provide the level of assistance as determined by the resident's individual assessment and Negotiated Service Plan." This Residential finding relates to Complaint IN00088036			
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure medications were given as ordered by the physician for 2 of 5 residents reviewed for medication administration in a total sample of 5. (Resident #N, Resident #O) Findings include:	R0241	Resident N and O had no adverse effects from not receiving medications. An audit of current Resident Medication Administration Records will be conducted by the Wellness Director or deignee to ensure that medications have been administered and ordered as indicated by staff initials.The	04/30/2011

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	1. Resident #N's record was reviewed on 3-25-2011 at 11:30 a.m. Resident #N's diagnoses included but were not limited to, diabetes, high blood pressure and high cholesterol. Resident #N's March physician's orders indicated he was to receive Flaxseed Oil 1000 mg 2 times per day initially ordered 6- 28-2010, Neurontin 300 mg at bedtime initially ordered 11-15-2010 and Ceftin 500 mg 2 times per day an antibiotic initially ordered 3-7-2011 to be given for 10 days for a urinary tract infection. Resident #N's March 2011 Medication Administration Record indicated he was scheduled to receive the Flaxseed Oil, Neurontin, and Ceftin at 8 a.m. and 8 p.m. The Medication Administration Record also indicated a circle around the initials for the Ceftin at 8 p.m. on 3-9-2011. There was no documentation on the back of the Medication Administration record to indicate why the initials had been circled. The initials were completed and not circled for the 8 p.m. Flaxseed oil and 8 p.m. Neurontin. A nurse's note, dated 3-9-2011, with no time indicated 8 p.m. .evening dose medications were missed.		Qualified Medical Assistants will be re educated on the rights of Medical Administration and proper documentation on the medication administration records including explanations of circled medications. The Wellness Director or designee will review the medication administration records twice weekly to ensure compliance with proper documentation for six weeks or until consistent compliance has been achieved. The Residence Director and or Regional Director od Quality Care and Management will randomly audit a sample of medical administration records for compliance during routine house checks at least monthly.	

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	In an interview 3-28-2011 at 2:30 p.m., QMA #2 indicated she had been the staff member responsible for giving medications on 3-9-2011 at 8 p.m., but was extremely busy on the evening of 3-9-2011 and had completely forgotten to give the medications, Flaxseed Oil, Nuerontin, and Ceftin. She further indicated she had initialed the medications as given, but the medications should have been circled and an explanation completed on the back of the Medication Administration Record to indicate why the medications had not been given. 2. Resident #O's record was reviewed 3-25-2011 at 11 a.m. Resident O's diagnoses included diabetes, high blood pressure, and coronary artery disease. Resident #O's physician's orders indicated she was to receive Flaxseed Oil 1000 mg 2 times per day initially ordered 6-28-2011. Resident #O's March 2011 Medication Administration Record indicated she was scheduled to receive the Flaxseed Oil at 8 a.m. and 8 p.m. The Medication Administration record had initials to indicate the Flaxseed Oil had been given. In a confidential interview with a staff			

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	member on 3-25-2011 at 12:05 p.m., the interviewee indicated Resident #O had not received her 8 p.m. medication on 3-9-2011. In an interview 3-28-2011 at 2:30 p.m., QMA #2 indicated she had been extremely busy on the evening of 3-9-2011 and had completely forgotten to give the medication. She further indicated the medication should have been circled and an explanation completed on the back of the Medication Administration Record to indicate why the medication had not been given. Page 14 of the Resident Handbook provided by the Administrator 8-25-2011 at 10:09 a.m., indicated the residence offers assistance with medications...in accordance with state law. A copy of the Wellness Resource Guide, dated 1-2010, indicated orders for services must be initiated. This Residential finding relates to Complaint number IN00088036.			
R0247	(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.			

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	Based on interview and record review, the facility failed to ensure a missed medication dose was noted in the resident's record for 1 of 5 residents reviewed for medication documentation in a total sample of 5. (Resident #O). Findings include : Resident #O's record was reviewed 3-25-2011 at 11 a.m. Resident O's diagnoses included diabetes, high blood pressure, and coronary artery disease. Resident #O's physician's orders indicated she was to receive Flaxseed Oil 1000 mg 2 times per day initially ordered 6-28-2010. Resident #O's March Medication Administration Record indicated she was scheduled to receive the Flaxseed Oil at 8 a.m. and 8 p.m. The Medication Administration record had initials to indicate the Flaxseed Oil had been given. In a confidential interview with a staff member on 3-25-2011 at 12:05 p.m., the interviewee indicated Resident #O had not received her 8 p.m. medication on 3-9-2011. In an interview 3-28-2011 at 2:30 p.m., QMA #2 indicated she had been	R0247	Resident N and O had no adverse effects from not receiving medications. An audit of current residents' Medication Administration Records will be conducted by the Wellness Director and/or designee to ensure that medication have been adminitered and ordered as indicated by staff initials.The Qulaified Medical Assistant will be retrained on the five rights of medicatio administration and proper documentation on the Medication Administration Records. Including explanations of circled medications. The Residence Director and/or degignee will re-educate the staff regarding notification and documentation of this. When a medication has been missed and there is a potential detrimental effect.The Wellness Director and/or deignee will review the Medication Administration Records twice weekly to ensure compliance with proper documentation for six weeks or until compliance had been achieved. The Residence Director and/or Regional Director of Quality Care Management will randomly audit a sampling of Medication Administration Records for compliance during routine house visits at least monthly.Staff will be re-educated completing Medication Adminitration Records and Resident Service Notes correctly. The Residence Director	04/30/2011

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	extremely busy on the evening of 3-9-2011 and had completely forgotten to give the medication. She further indicated she had initialed the medication as given, however the medication should have been circled and an explanation completed on the back of the Medication Administration Record to indicate why the medication had not been given. A review of the Resident Service notes for Resident #O did not include an entry between 1-28-2011 and 3-10-2011. The note for 3-10-2011 did not include information relating to the Flaxseed Oil medication not being given. In an interview on 3-25-2011 at 2:10 p.m., the Wellness Director indicated the medication that was missed should have been documented in the Resident Service notes. On 3-29-2011 at 9:45 a.m., the Administrator provided a policy entitled Routine medications dated 7/2009. The policy did not indicated the proper documentation for missed medications. This Residential finding relates to Complaint number IN00088036		and/or Wellness Director will review current resident records to ensure that resident records and Medication Administration Records are in compliance.	

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R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure missed medications were accurately documented in the medical record for 1 of 5 residents reviewed for medication documentation in a total sample of 5. (Resident #O) Findings include: Resident #O's record was reviewed 3-25-2011 at 11 a.m. Resident O's diagnoses included diabetes, high blood pressure, and coronary artery disease. Resident #O's physician's orders indicated she was to receive Flaxseed Oil 1000 mg 2 times per day initiated 6-28-2011. Resident #O's March Medication Administration Record indicated she was scheduled to receive the Flaxseed Oil at 8 a.m. and 8 p.m. The Medication Administration record had initials to indicate the Flaxseed Oil had been given. In a confidential interview on 3-25-2011	R0349	Staff will be retrained regarding proper documentation protocol.Resident was not affected as a result from this deficient practice.The Qualified Medical Assistant has been re-educated on correctly completingMedication Administration Records and on protocol for passing medications.The Wellness Director and/or Deignee will review new orders weekly to ensure proper transcription of Physician orders on the Medication Administration Records. Finding will be reviewed and corrected through our QA process as an ongoing process. The regional Director of Quality and Care Management and/or Regional Dorector of Operations will randomly elect records to review during routine ite visits at least monthly.	05/06/2011

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	at 12:05 p.m., the interviewee indicated Resident #O had not received her 8 p.m. medication on 3-9-2011. In an interview 3-28-2011 at 2:30 p.m., QMA #2 indicated she had been extremely busy on the evening of 3-9-2011 and had completely forgotten to give the medication. She further indicated she initialed the medication as if it had been given, however, the medication should have been circled and an explanation completed on the back of the Medication Administration Record to indicate why the medication had not been given. In an interview on 3-25-2011 at 2:10 p.m., the Wellness Director indicated the medication that was missed should have been circled on the Medication Administration Record. On 3-29-2011 at 9:45 a.m., the Administrator provided a policy entitled Routine medications dated 7/2009. The policy did not indicated the proper documentation for missed medications. This Residential finding relates to Complaint number IN 00088036.			